JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
OFFICE OF FINANCIAL AND INSURANCE SERVICES
DEPARTMENT OF LABOR & ECONOMIC GROWTH
David C. Hollister, Director

LINDA A. WATTERS
COMMISSIONER

June 20, 2005

To: The Honorable Michael D. Bishop, Chair
Senate Banking and Financial Institutions Committee

The Honorable Joe Hune, Chair
House Insurance Committee

Dear Chair Bishop and Chair Julian:

In accordance with section 1401(9) of The Nonprofit Health Care Corporation Reform Act, 1980 PA 350, MCL 550.1401(9), attached please find the report on Denial of Health Coverage by Blue Cross Blue Shield of Michigan dated June 20, 2005.

Please feel free to contact me if you have any questions regarding this matter.

Sincerely,

Linda A. Waters
Commissioner

Attachment

STATE OF MICHIGAN
DEPARTMENT OF LABOR AND ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE SERVICES

A Report on Denial of Health Coverage by Blue Cross Blue Shield of Michigan
June 20, 2005

Background:

The Michigan Office of Financial and Insurance Services (OFIS) regulates health insurers doing business in Michigan: health maintenance organizations (HMO's), commercial insurers, and Michigan's only non-profit health care corporation, Blue Cross Blue Shield of Michigan (BCBSM). Because BCBSM is the insurer of last resort for Michigan's citizens and must accept all who apply for coverage regardless of health status, the state is particularly interested in instances when BCBSM denies an employer group's application for group health coverage.

Legislation:

MCL 550.1101 et seq., also known as, P.A. 350 of 1980 (the Act), is the enabling act of BCBSM. MCL 550.1401(4)(d) defines the circumstances under which BCBSM may deny health coverage to a group applying for coverage. The Act also includes provisions addressing groups whose applications are for renewal coverage with BCBSM. MCL 550.1401(4)(d) applies to groups with fewer than 100 subscribers, except for employer groups with 2-50 employees that must meet more specific criteria found in MCL 500.3709.

MCL 550.1401(4)(d) allows BCBSM to deny a resident of this state coverage under a group certificate if the individual's group has failed to enroll enough of its eligible members with the health care corporation. A denial under MCL 550.1401(4)(d) shall be made only if the health care corporation (BCBSM) determines that the cost for the portion of the group applying for coverage would be at least 50% more on a per subscriber basis than the per subscriber cost for the whole group. A denial under this subdivision shall not be based on the health status of any individual in the group or his or her dependent.

Specifically, subsections (i)(ii) and (iii) state that a denial of coverage can be made if BCBSM can demonstrate that the denial is based on sound actuarial principles and may be based on one or more of any of the following:

(i) That the contract holder for the group applying for coverage is also offering a self-funded health benefit plan.

(ii) That the group applying for coverage is composed entirely of the contract holder's retiree business segment.

(iii) That the average individual age of the members of the group applying for coverage is either 50% higher or 10 years higher than the average individual age for the whole group.

MCL 550.1401(9) requires that BCBSM notify the commissioner of any denial made under subsection (4)(d) [MCL 550.1401(4)(d)] and provide the information used in making the determination. Further, the commissioner must approve or disapprove BCBSM's determination.

Finally, the commissioner is to report to the senate and house of representatives, by May 15, 2005 and biennially thereafter, regarding BCBSM's denials of coverage pursuant to section 550.1401(4)(d).

Outcomes:

The commissioner is required to specifically report on four items. As of this date, the data are as follows:

a) The number of denials made each calendar year by a health care corporation under subsection (4)(d):

July 23, 2003 to December 31, 2003: 0
January 1, 2004 to December 31, 2004: 1
January. 1, 2005 to May 15, 2005: 4

b) The number of denials under subdivision (a) that were approved by the commissioner under this subsection and a summary of the type of group approved:

All five denials met the requirements of MCL 500.1401(4)(d). Of the five denials:
3 – Applied to contract holders for groups also offering a self-funded benefit plan [MCL 550.1401(9)(d)(i)].
1 – Applied to a group composed entirely of the contract holder's retiree business segment [MCL 550.1401(9)(d)(ii)].
1 – Applied to a group where the average individual age of the members of the group applying for coverage is either 50% higher or 10 years higher than the average individual age of the whole group [MCL 550.1401(9)(d)(iii)].

c) The number of denials under subdivision (a) that were disapproved by the commissioner under this subsection and a summary of the type of group disapproved.

The commissioner disapproved no BCBSM denials.

d) The number of decisions by the commissioner under this subsection that have been appealed and the results of the appeals.

No decisions have been appealed.

Each of these reasons for denial of coverage is allowed by the above-cited statute. OFIS finds no violations on the part of BCBSM.